| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155003 | A. BUILDING 00<br>B. WING | 08/25/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MASON HEALTH CARE CENTER | 900 PROVIDENT DR<br>WARSAW, IN46580 |

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| F0000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey Dates: August 22, 23, 24, 25, 2011<br><br>Facility number: 000003<br>Provider number :155003<br>AIM number: 100290600<br><br>Survey team:<br>Julie Wagoner, RN, TC<br>Tim Long, RN (08/22, 08/23, 08/24, 2011)<br>Christine Fodrea, RN<br><br>Census bed type:<br>SNF: 04<br>SNF/NF: 87<br>Total: 91<br><br>Census payor type:<br>Medicare: 16<br>Medicaid: 56<br>Other: 19<br>Total: 91<br><br>Sample: 19<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. | F0000 | September 13, 2011 Mrs. Kim Rhoades, DirectorLong Term Care DivisionIndiana State Department of Health2 N. Meridian StreetIndianapolis, Indiana 46204 Re: Mason Health Care Provider Number: 155003Survey Dates: August 22-25, 2011 Dear Mrs. Rhoades: Enclosed please find our completed plan of correction responding to the recertification survey conducted at our facility ending 8/25/11 and the 2567 dated 8/25/11. All POC measures have been or will be fully implemented by September 24, 2011. Mason Health Care respectfully asks that our plan of correction be considered to serve as our allegation of compliance for the cited tags F225, F226, F282, F315, F332, F441 and F514, as of that date. I hereby request a quick return of the survey team to clear all cited tags. As noted on the plan of correction, the POC should not be construed as an admission as to the validity of any of the citations. Please be assured, however, that although the facility disagrees with the citations, we have considered the survey concerns very seriously and have undertaken the necessary measures to ensure findings of compliance as of September 24. 2011. Quality monitoring and in-services will be provided on a | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Quality review completed on September 1, 2011 by Bev Faulkner, RN | | continuing basis to assure an ongoing understanding and implementation of policies and procedures to ensure continued compliance. Please contact me with any questions or concerns you may have. Thank you in advance for your cooperation and assistance in this matter. Sincerely, Lillian J. Horton, HFA, MHAMason Health CareAdministrator | |

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| F0225 SS=D | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on interview and record review, the facility failed to ensure 1 staff member reported an allegation of abuse to the administrator immediately for 1 of 1 residents who alleged abuse. (Resident | F0225 | 1.) Facility Disclaimer<br>2.) Credible Allegation of Substantial Compliance<br>This Plan of Correction (POC) is | 09/24/2011 |

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| | #105)<br><br>Finding includes:<br><br>During the Resident/Surveyor group meeting, conducted on 08/23/11 at 10:00 A.M., Resident #105 indicated a third shift aide had spoken to her rudely regarding her need for an incontinence brief. She indicated she had reported the incident right away to the nurse.<br><br>The Administrator was queried, during the daily exit conference on 08/23/11 at 3:30 P.M., regarding the incident and the investigation of the incident was requested. However, the Administrator indicated she had no knowledge of the incident. A brief summation of the allegation was given to the Administrator during the daily exit conference.<br><br>On 08/25/11 at 10:10 A.M., the Administrator indicated she had started the investigation of the alleged verbal abuse by an unidentified staff member to Resident #105. She indicated she had verified with RN #16, a staff nurse, that a few weeks ago the Resident #105 had reported the incident and the nurse had failed to follow the facility's abuse protocol and notify the Administrator immediately of the allegation. The Administrator indicated she had | | prepared and executed because it is required by the provisions of State and Federal Law, and not because Mason Health Care agrees with the allegations contained there-in. Mason Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capability to render adequate care.<br>Please let these POC responses serve as the facilities Credible Allegation of Compliance 9/24/11.<br><br>F-225 Investigate/Report Allegations/Individuals:<br>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.<br>It is facility practice to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aid registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; | |

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| | suspended RN #16 because she had failed to follow the facility's abuse policy and procedure. She indicated she had also reported the incident to the Indiana State Department of Health as required. She indicated at the present time, the perpetrator could not be identified due to the resident's inability to remember the aide's name or description.<br><br>A copy of a written statement by RN #16, completed on 08/25/11, indicated on 07/22/11 Resident #105 had alleged that "someone told her that she was too big of a girl to pee on herself."<br><br>On 08/25/11 at 4:45 P.M., immediately following the final exit conference, the Administrator indicated the facility had previously been cited for the same issue and the allegation had been made prior to the facility's plan of correction date for the tag. In addition, the Administrator indicated she had additional documentation of an interview, conducted recently with Resident #105 in which she had denied any concerns regarding any allegation of verbal abuse or rudeness. The administrator showed an interview document with "yes" marked next to the question regarding had any staff member verbally abused or been rude to them. The Administrator indicated the "yes" was "not about that" but she did not elaborate | | and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br>It is facility practice to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with State law through established procedures including to the State survey and certification agency).<br>It is facility practice to have evidence that all alleged violations are thoroughly investigated; and to prevent further potential abuse while the investigation is in progress.<br>It is facility practice to ensure that the results of all investigations are reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken.<br>1. An intternal investtgatton was inittatted and ISDH nottffied offi alleged allegatton offi abuse by resident#105.<br>2. Sttaffi intterviewed tto ensure no otther allegattons offi abuse has been verbalized by a residentt Iffi tthere are | |

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| | on what incident the resident was referring to and then the Administrator indicated she would not provide a copy of the document because it was part of the facility's "QA" process.<br><br>3.1-28(c) | | any otther allegattons reportted an intternal investtgatton will be inittatted and our abuse policy ffiollowed<br>3. Sttaffi will be reinserviced on whatt is an allegatton, when tto nottffiy tthe Administtrattor and tthe abuse policy.<br>4. Administtratto/designee will monittor weekly by randomly selecttng tthree residentts and intterviewing tthem regarding ttheir care and ttreattmentt while att Mason Healtth Care This will conttnue x 4 wk tthen monittored tthru.Q. montthly x2, tthen quartterly tthereaffier This will also be discussed in Residentt Council montthly witth any concerns ffiorwarded tto tthe Administtrattor immediattely<br>5. Septtember24, 2011. | |
| F0226 SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on interview and record review, the facility failed to ensure 1 staff followed the abuse policy and procedure regarding reporting abuse to the administrator immediately for 1 of 1 residents who alleged abuse. (Resident #105)<br><br>Finding includes:<br><br>During the Resident/Surveyor group meeting, conducted on 08/23/11 at 10:00 A.M., Resident #105 indicated a third | F0226 | F-226 Develop/Implementt Abuse/Neglectt,ETC Policies:<br>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render | 09/24/2011 |

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| | shift aide had spoken to her rudely regarding her need for an incontinence brief. She indicated she had reported the incident right away to the nurse.<br><br>The Administrator was queried, during the daily exit conference on 08/23/11 at 3:30 P.M., regarding the incident and the investigation of the incident was requested. However, the Administrator indicated she had no knowledge of the incident. A brief summation of the allegation was given to the Administrator during the daily exit conference.<br><br>On 08/25/11 at 10:10 A.M., the Administrator indicated she had started the investigation of the alleged verbal abuse by an unidentified staff member to Resident #105. She indicated she had verified with RN #16, a staff nurse, that a few weeks ago the Resident #105 had reported the incident and the nurse had failed to follow the facility's abuse protocol and notify the Administrator immediately of the allegation. The Administrator indicated she had suspended RN #16 because she had failed to follow the facility's abuse policy and procedure. She indicated she had also reported the incident to the Indiana State Department of Health as required. She indicated at the present time, the perpetrator could not be identified due to | | adequate care.<br>Itt is ffiacilitty practtce tto develop and implementt written policies and procedures tthatt prohibitt misttreattment, neglectt, and abuse offi residentts and misappropriatton offi residentt propertty<br>1. An intternal investtgatton was inittatted and ISDH nottffied offi alleged allegatton offi abuse by resident #105.<br>2. Sttaffi intterviewed tto ensure no otther allegattons offi abuse has been verbalized by a residentt Iffi tthere are any otther allegattons reportted an intternal investtgatton will be inittatted and our abuse policy ffiollowed<br>3. Sttaffi will be reinserviced on whatt is an allegatton, when tto nottffiy tthe Administtrattor and tthe abuse policy.<br>4. Administtratto/designee will monittor weekly by randomly selecttng tthree residentts and intterviewing tthem regarding ttheir care and ttreattmentt while att Mason Healtth Care This will conttnue x 4 wk tthen monittored tthru Q. montthly x2, tthen quartterly tthereaffier. This will also be discussed in Residentt Council montthly witth any concerns ffiorwarded tto tthe Administtrattor immediattely<br>5. Septtember 24, 2011. | |

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| | the resident's inability to remember the aide's name or description.<br><br>A copy of a written statement by RN #16, completed on 08/25/11, indicated on 07/22/11 Resident #105 had alleged that "someone told her that she was too big of a girl to pee on herself."<br><br>On 08/25/11 at 4:45 P.M., immediately following the final exit conference, the Administrator indicated the facility had previously been cited for the same issue and the allegation had been made prior to the facility's plan of correction date for the tag. In addition, the Administrator indicated she had additional documentation of an interview, conducted recently with Resident #105 in which she had denied any concerns regarding any allegation of verbal abuse or rudeness. The administrator showed an interview document with "yes" marked next to the question regarding had any staff member verbally abused or been rude to them. The Administrator indicated the "yes" was "not about that" but she did not elaborate on what incident the resident was referring to and then the Administrator indicated she would not provide a copy of the document because it was part of the facility's "QA" process.<br><br>Review of the facility's policy and | | | |

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| | procedure, titled, Abuse, Neglect, and Misappropriation of Resident Property, dated 08/2010, and indicated as current included the following: "...8. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with state law through established procedures....."<br><br>3.1-28(a) | | | |
| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, interview and record review, the facility failed to apply TED (antiembolism stockings) hose as ordered by the physician for 1 of 2 residents reviewed with TED hose in a sample of 19. (Resident #76)<br><br>Findings include: | F0282 | F 282-Services by Qualiffied Persons/Per Care Plan:<br>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or | 09/24/2011 |

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| | Resident #76's record was reviewed 8/23/2011 at 4:00 P.M. Resident #76's diagnoses included but were not limited to Alzheimer's dementia, high blood pressure, and osteoporosis.<br><br>A current physician's order, dated 5/25/2011, indicated knee high TED hose were to be applied in the morning and removed in the evening.<br><br>On 8/22/2011 at 12:25 P.M., Resident #76 was observed sitting up in her wheelchair in her room while LPN #7 was administering noon medications. Resident #76 was not wearing TED hose.<br><br>On 8/23/2011 at 8:45 A.M., Resident #76 was observed sitting up in her wheel chair in her room. She was not wearing TED hose.<br><br>On 8/23/2011 at 10 A.M., Resident #76 was observed in her wheel chair in the hall. She was not wearing TED hose.<br><br>On 8/23/2011 at 4:25 P.M. Resident #76 was observed in her room in bed. She was not wearing TED hose.<br><br>In an interview on 8/24/2011 at 10:05 A.M., LPN #6 indicated Resident #76 should have her TED hose on. | | collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.<br>Itt is ffiacilitty practtce tto ensure tthatt services provided or arranged by tthe ffiacilitty are provided by qualiffied persons in accordance witth each residentt's written plan offi care<br>1. Correcttve actton cannott be ttaken regarding tthe alleged defficiency d/tt tthe occurrence happened in tthe pastt<br>2. All residentts have tthe pottenttal tto be affiectted by tthe alleged defficiency<br>3. Nursing sttaffi will be reinserviced on ffiollowing each residentt's plan offi care C.N.A. assignmentt sheetts will be reviewed and updatted as needed<br>4. Residentts witth speciffic needs (i.e. tted hose) will be identtffied tthru ttheir care plans DON/designee will conductt ffiacilitty rounds 5x/wk x 6wk tto ensure all intterventtons are implementted This will tthen be monittored tthru QA. quartterly unttl 100% compliance is achieved.<br>5. Septtember 24, 2011. | |

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| | In an interview on 8/24/2011 at 10:10 A.M., RN #5 indicated if Resident #76 would have refused her TED hose, it would have been documented on the treatment record.<br><br>A review of the treatment record, dated 8/2011, indicated on the dates of 8/22 and 8/23/ 2011, Resident #76 was wearing her TED hose.<br><br>3.1-35(g)(2) | | | |
| F0315 SS=D | Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br>Based on observation, record review, and interview, the facility failed to ensure a decline in bladder continency was identified and assessed and the resident was provided appropriate treatment and services in an attempt to restore or improve the bladder function for 1 of 6 | F0315 | F-315: No CatthetterPreventt UTI Resttore Bladder<br>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The | 09/24/2011 |

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| | residents reviewed for incontinence in a sample of 19. (Resident #27)<br><br>Finding includes:<br><br>1. During the initial tour of the facility, conducted on 08/22/11 between 10:30 A.M. - 11:30 A.M., the Unit Manager, LPN #9, indicated Resident #27 was confused, required extensive staff assistance for activities of daily living, had an intestinal infection, was incontinent of her bladder, and was on a specific toileting plan.<br><br>Resident #27 was observed on 08/23/11 at 2:58 P.M., in a recliner in the lounge. The resident was heard asking to go to the bathroom. The resident was assisted to her wheelchair, taken to her room, and toileted on a bedside commode. The resident did not void.<br><br>The clinical record for Resident #27 was reviewed on 03/23/11 at 11:50 A.M. The initial Minimum Data Set (MDS) assessment for Resident #27,. completed on 05/27/11 indicated the resident was occasionally (more than twice during the assessment period but not daily) incontinent of her bladder. A toileting plan was initiated on 05/14/11, prior to the assessment. | | facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.<br>Itt is ffiacilitty practtce tto ensure tthatt based on tthe residentt's comprehensive assessmentt tthe ffiacilitty ensures tthatt a residentt who entters tthe ffiacilitty witthoutt an indwelling catthetter is nott catthetterized unless tthe residentt's clinical conditton demonsttrattes tthatt cattherizatton was necessary and a residentt who is inconttnentt offi bladder received appropriatte ttreattmentt and services tto preventt urinary ttractt inffiecttons and tto resttore as much normal bladder ffiunctton as possible.<br>1. Residentt#27's Bowel and Bladder assessmentt and care plan will be updatted tto reffiectt tthe change in inconttnence.<br>2. All residentts have tthe pottenttal tto be affiectted by tthe alleged defficiency<br>3. A new nurse has been designatted tto manage tthe Bowel and Bladder program; she will receive one on one inservicing on tthe ffiacilittes updatted policy<br>4. DON/Licensed designee will monittor all residentts ffior a change in ttheir conttnence tthru tthe mostt currentt MDS5x/wk x 6wk. Monittoring will tthen occur montthly tthru Q.A.unttl 100% compliance is | |

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| | The most recent quarterly MDS assessment review, completed on 07/14/11 indicated the resident had declined and was now frequently incontinent of her bladder (daily incontinent but has some control at times). A "quarterly review/update", completed on 07/14/11 indicated "NO" was marked for changes in assessment or 3 day void (pattern).<br><br>Interview on 08/25/11 at 4:00 P.M., with the MDS Coordinator, RN #10 and Corporate RN #11, indicated a previous employee had mismarked the Quarterly review/update form. They presented a voiding pattern record form, completed on 07/15/11, 07/16/11, and 07/17/11. There was no other assessment completed regarding the decline in bladder continency for Resident #27.<br><br>The current care plan had been reviewed and no changes had been made; however, the care plan review date was 07/15/11 prior to the voiding patterning record completion date. The current care plan indicated the resident was "occasionally incontinent of her bowels and bladder" and was to be toileted at 6:00 A.M., 9:00 A.M., 1:00 P.M., 6:00 P.M., and 9:00 P.M., and as needed.<br><br>Review of the facility policy and | | achieved.<br>5. Septtember24, 2011. | |

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| | procedure, titled, Bowel and Bladder Assessment, revised as of November 2008, and indicated by RN #11 as the current policy indicated the bladder assessment form was to be completed on all residents at the time of admission, if they developed incontinence, after removing or utilizing a urinary catheter, and for bladder retraining or incontinence management. RN #11 indicated it did not specifically instruct nursing staff to complete a new assessment if the resident's bladder incontinence worsened and she was unclear what was intended in the policy regarding bladder retraining or incontinence management.<br><br>3.1-41(a)(2) | | | |
| F0332 SS=D | The facility must ensure that it is free of medication error rates of five percent or greater.<br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 12 residents observed receiving medications. Three (3) errors in medication were observed during 40 opportunities for error in medication | F0332 | F-332 Free of Medication Error Rates of 5% or more: This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. | 09/24/2011 |

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| | administration. This resulted in a medication error rate of 7.5 %. (Residents #72 and # 31)<br><br>Findings include:<br><br>1. Resident # 72 was observed on 8/22/11 receiving his Humulin R-100, 3 units, administered by LPN #1 per physician's order at 10:52 A.M. The resident was observed receiving his meal at 12:16 P.M., in the assist dining room. This was 84 minutes after the resident received the insulin. The resident was not experiencing any obvious adverse effects from early administration of Humulin R. The scheduled time for the lunch meal in the assist dining room was 12:15 P.M.<br><br>Resident # 72 was observed on 8/24/11 receiving his Humulin R-100, 3 units, administered by LPN #1, per physician's order at 11:10 A.M. The resident was observed receiving his meal at 12:13 P.M. in the assist dining room. This was 63 minutes after the resident received the insulin. The resident was not experiencing any obvious adverse effects from early administration of Humulin R. The scheduled time for the lunch meal in the assist dining room is 12:15 P.M.<br><br>Review of Resident #72's most recent physician's orders from 8/1/11 indicated | | The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. It is facility practice to ensure that it is free of medication error rates of five percent or greater. 1. Corrective action cannot be taken for residents #31 or #72 due to the alleged deficiency occurred in the past. 2. All insulin dependent residents have the potential to be affected by the alleged deficiency. 3. Nurses will be inserviced on correct policy and procedure when administering insulin. 4. DON/Licensed designee will monitor residents receiving insulin to ensure administration occurs within 30 minutes before the resident's next meal. This will be done 3x/wk x 6wk then be monitored thru Q.A. quarterly until 100% compliance is achieved. 5. September 24, 2011. Addendum:Licensed Unit Managers, or licensed designee, will observe insulin administration for those residents requiring injection 5-10 minutes before a meal 3x/wk x 6 wk then be monitored thru Q.A. quarterly until 100% compliance is achieved. | |

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| | Humulin R was to be administered subcutaneous per sliding scale before meals and at bedtime everyday.<br><br>Review of the 2010 Nursing Spectrum Drug Handbook indicated Humulin R was a short acting insulin with a 30 - 60 minute onset of function with a peak function between 2 - 4 hours after given. Under the Administration recommendations it indicated it was to be administered 30 minutes prior to a meal.<br><br>2. Resident # 31 was observed on 8/24/11 receiving his Humalog, 7 units, administered by LPN #1, per physician's order at 11:20 A.M. The resident was observed receiving her meal at 12:18 P.M. in the main dining room. This was 58 minutes after the resident received her insulin. The resident was not experiencing any obvious adverse effects from early administration of Humalog. The scheduled time for the lunch meal in the main dining room is 12:20 P.M.<br><br>Review of Resident #31's most recent physician's orders from 8/1/11 indicated Humalog was to be administered subcutaneous per sliding scale before meals and at bedtime everyday.<br><br>Review of the 2010 Nursing Spectrum Drug Handbook indicated Humalog was | | | |

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| | rapid acting insulin with a 15 minute onset of function with a peak function between 30 - 90 minutes after administered. Under the Administration recommendations it indicated it was to be administered 5 - 10 minutes prior to a meal.<br><br>An interview with the Director of Nursing (DN) on 8/24/11 at 1:40 P.M., indicated the facility policy is to administer insulin ordered before a meal within 30 minutes of the scheduled time for the meal.<br><br>Review of the facility policy titled "Injections Subcutaneous Insulin" revised 9/2005, indicated<br>#15: "Insulin needs to be administered 30 minutes before the next scheduled meal, unless specifically ordered otherwise by the physician."<br><br>3.1-25(b)(9)<br>3.1-48(c)(1) | | | |

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| F0441 SS=D | The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation, record review and interview the facility failed to ensure 2 of 4 licensed nurses (LPN #1, LPN #3), observed obtaining blood glucose levels, followed instructions for proper sanitation | F0441 | F-441 Infection Control, Prevent Spread, Linens: This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health | 09/24/2011 |

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| | of the glucometers. This practice had the potential to affect 23 of 91 residents in the facility who received glucometer checks. In addition, the facility failed to ensure 3 of 4 staff members (CNAs # 12, #13, #15 and COTA #14) followed isolation precautions for 2 of 2 residents in contact isolation in a sample of 19. (Residents #27 and #63)<br><br>Findings include:<br><br>1. On 8/22/11 at 11:11 A.M., LPN #1 was observed checking blood glucose levels for Resident #21. LPN #1 wiped the outside of the glucometer for 5 seconds with Super Sani-Cloth wipes and left the glucometer on the medication cart.<br><br>On 8/23/11 at 11:28 A.M., LPN #3 was observed checking blood glucose levels for Resident #11. LPN #3 wiped the outside of the glucometer with Super Sani-Cloth wipes for 10 seconds and left the glucometer on the medication cart.<br><br>An interview with LPN #3 on 8/23/11 at 11:35 A.M., indicated for glucometer cleaning each medication cart has two glucometers and the procedure is to wipe off the soiled glucometer and let air dry for 5 minutes and alternate glucometers.<br><br>On 8/24/11 at 11:00 A.M., LPN #1 was | | Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. It is facility practice to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. It is facility practice to establish and Infection Control Program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. It is facility practice that when the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility isolates the resident; prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted | |

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| | observed checking blood glucose levels for Resident #72. LPN #1 wiped the outside of the glucometer with Super Sani-Cloth wipes for 5 seconds and left the glucometer on the medication cart. On 8/24/11 at 11:15 A.M., LPN #1 checked the blood glucose level for Resident #31 using the same glucometer as Resident #72. After checking Resident #31's blood glucose level, LPN #1 wiped the outside of the glucometer for 5 seconds with Super Sani-Cloth wipes.<br><br>Review of the facility policy "Glucometer Cleaning/Disinfecting Policy," revised January 2010 indicated "3. Clean/disinfect glucometer by wiping the outside of the glucometer with disinfectant wipe. (See Manufacturer's Guidelines.)"<br><br>Review of the manufacturer's instructions for Super Sani-Cloth wipes indicated to disinfect and deodorize: "Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time. Let air dry." | | professional practice. It is facility practice that personnel must handle, store, process and transport lines so as to prevent the spread of infection. 1. Corrective action cannot be taken due to the alleged deficiency occurred in the past. 2. All residents have the potential to be affected by the alleged deficiency. 3. Staff will be reinserviced on isolation precautions. Nurses will be reinserviced on proper procedure for proper sanitation of the glucometers. 4. DON/designee will observe staff for proper procedures when interacting with a resident on isolation precautions. Nurses will be observed cleaning their glucometers to ensure proper sanitation. This monitoring will occur 3x/wk x 6wk then quarterly thru Q.A. until 100% compliance is achieved. 5. September 24, 2011. Addendum:Resident #27 to be educated regarding the appropriate hand washing technique, if able, and the Licnesed Unit Manager, or licensed designee, to observe the resident technique 1x/wk. If not able to teach the resident, then CNA to ensure the resident is capable of appropriate hand washing technique. If unable, then the CNA to wash the resident's hands ensuring appropriate technique is accomplished after using the toilet. Licensed Unit Manager, or licensed designee, will observe | |

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| | 2. During the initial tour of the facility, conducted on 08/22/11 between 10:45 A.M. - 11:15 A.M., the Unit Manager, LPN #9, indicated Resident #27 was in contact isolation due to a bowel infection. She indicated the resident was incontinent of her bowels and bladder and was toileted at specific times.<br><br>On 08/23/11 at 2:56 P.M., Resident #27 was seated in a recliner in the lounge on the secured unit. She verbalized the need to go to the bathroom. At 3:00 P.M., Resident #27 was transferred to her wheelchair and taken to her room. CNA's #12 and 13 donned gloves and proceeded to transfer the resident from her wheelchair onto a bedside commode. CNA #12 removed the resident's brief and placed it in a trash can. CNA #12 then removed her gloves, held them in one hand, exited the room, and returned after retrieving a red trash bag. She then proceeded to lift the lid of a red trash can in the room, place the gloves in the trash can, and put a new pair of gloves on her hands.<br><br>After the resident had attempted to void, she was instructed to wipe herself with disposable wipes and then to wipe her hands with a different disposable wipe. | | CNA for those residents not able to perform the task 1x/wk. | |

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| | Both CNA's removed their gloves and washed their hands, but the resident was not assisted to wash her hands prior to exiting the room.<br><br>The clinical record for Resident #27 was reviewed on 08/23/11 at 11:15 A.M. The resident had diagnosis including Clostridium difficile (a bowel infection). The resident was receiving the medications Diff Stat and Flagyl to treat the infection. The resident was diagnosed with the infection on 08/15/11.<br><br>3. During the initial tour of the facility, conducted on 08/22/11 between 10:30 A.M. - 11:15 A.M., LPN #9 indicated Resident #63 was in contact isolation due to a bowel infection. She indicated the resident was confused, incontinent of his bowels and was assisted to toilet.<br><br>On 08/24/11 at 9:30 A.M., Resident #63 was observed being transferred by Employee #14, a Certified Occupational Therapy Assistant (COTA), and CNA #15 from his recliner to his wheelchair. Neither employee washed their hands or put on gloves. CNA #15 removed a gait belt from around her waist and placed the gait belt around Resident #63. Both, she and the COTA, transferred the resident to his wheelchair. CNA #15 then replaced | | | |

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| | the gait belt around her waist and the COTA pushed Resident #63 in his wheelchair out of the room to the therapy room. Neither employee washed their hands or instructed the resident to wash his hands prior to exiting the room.<br><br>The clinical record for Resident #63 was reviewed on 08/24/11 at 9:15 A.M. Resident #63 was admitted to the facility from an acute care facility on 06/20/11. The resident had diagnoses, including but not limited to, Clostridium difficile (a bowel infection). The resident was receiving the antibiotics, Vancomycin and Flagyl to treat his bowel infection.<br><br>4. Review of the facility policy and procedure, from an APIC infection control toolkit, dated 2003, titled, "Policy for Clostridium difficile" indicated the following: "It is the policy of this facility to institute contact precautions for residents with Clostridium difficile, pseudomembranous colitis, or antibiotic-associated colitis who are exhibiting diarrhea stools due to the infection in the following situations: when the resident is incontinent and soiling of the environment with stool is likely, when the resident is noncompliant with basic personal hygiene and handwashing, when contaminated stool cannot be contained, when the resident is | | | |

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| | confused and cannot comply with appropriate hygiene measures..."<br><br>Review of the most current APIC "Guide to the Elimination of Clostridium difficile in Healthcare Settings" indicated the following recommendations: "...gloves must be donned before entering the room and worn by all healthcare providers during patient care and when in contact with the patient's environment....When a patient has CDI (Clostridium difficile), patient transportation and movement outside the room or cubicle should be limited to medically necessary purposes. Patients should be taught to perform hand hygiene prior to movement from their room...Personnel should be sure to clean and disinfect all patient care equipment that has been contaminated. Reusable equipment must be cleaned and disinfected between patients. Whenever possible, each patient should be assigned his or her own equipment to minimize cross-contamination...."<br><br>Interview with the Director of Nursing, on 08/25/11 at 11:00 A.M., indicated she had the 2008 manual for Clostridium difficile. Interview with the Regional Nurse Consultant, RN #15, on 08/25/11 at 3:00 P.M., indicated she had more information regarding the concern with the facility's outdated policy; however, on 08/26/11 a | | | |

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| | 155003 | A. BUILDING 00<br>B. WING | 08/25/2011 |

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| | fax was received indicating the facility had no more information regarding the issue.<br><br>3.1-18(b)(2) | | | |
| F0514<br>SS=E | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>Based on interview and record review, the facility failed to maintain accurate and complete records for 4 of 19 residents reviewed for complete records. The facility failed to ensure accurate documentation for 1 of 3 residents reviewed for TED hose application documentation (Resident #76). The facility failed to ensure accessibility of documentation for 2 of 3 residents | F0514 | F-514-Records-Complette/Accuratte/Accessible:<br>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor | 09/24/2011 |

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| | reviewed for intake and output records (Resident #91 and Resident #58) and for 1 of 19 residents reviewed for physician notification documentation (Resident #100).<br><br>Findings include:<br><br>1. Resident #76's record was reviewed 8/23/2011 at 4:00 P.M. Resident #76's diagnoses included but were not limited to Alzheimer's dementia, high blood pressure, and osteoporosis.<br><br>A current physician's order, dated 5/25/2011, indicated knee high TED hose were to be applied in the morning and removed in the evening.<br><br>On 8/22/2011 at 12:25 P.M., Resident #76 was observed sitting up in her wheelchair in her room while LPN #7 was administering noon medications. Resident #76 was not wearing TED hose.<br><br>On 8/23/2011 at 8:45 A.M., Resident #76 was observed sitting up in her wheel chair in her room. She was not wearing TED hose.<br><br>On 8/23/2011 at 10 A.M., Resident #76 was observed in her wheel chair in the hall. She was not wearing TED hose. | | are they of such character so as to limit our capability to render adequate care.<br>It is facility practice to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br>It is facility practice to ensure that the clinical record contains sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>1. Correcttve actton cannott be ttaken ffior residentt#76, #58 and #91 due tto tthe alleged defficiency occurred in tthe pastt.Residentt#100 has discharged ffirom tthe ffiacilitty<br>2. All residentts have tthe pottenttal tto be affiectted by tthe alleged defficiency.<br>3. Nursing sttaffi will be reinserviced on ffiollowing residentt's plan offi careC.N.A. assignmentt sheetts will be reviewed and updatted as needed. The electtronic medical record conffiguratton has been changed tto allow ffior accuratte&D ttottal.stthis change correctts residentt #58's record. The business office manager has been insttructted tto use tthe error ffiunctton versus tthe delette ffiunctton when adjusttng tthe census line. Nurses will be reinserviced on proper documenttatton offi physician | |

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| | On 8/23/2011 at 4:25 P.M., Resident #76 was observed in her room in bed. She was not wearing TED hose.<br><br>In an interview on 8/24/2011 at 10:05 A.M., LPN #6 indicated Resident #76 should have her TED hose on.<br><br>In an interview on 8/24/2011 at 10:10 A.M., RN #5 indicated if Resident #76 would have refused her TED hose, it would have been documented on the treatment record.<br><br>A review of the treatment record, dated 8/2011, included documentation on the dates of 8/22 and 8/23/2011, indicating Resident #76 was wearing her TED hose, even though the resident was observed on those dates not wearing TED hose.<br><br>2. Resident #58's record was reviewed 8/22/2011 at 12:10 P.M. Resident #58's diagnoses included but were not limited to depression, diabetes, and breast cancer.<br><br>Review of intake and output records for 8/2011 indicated on 8/14/2011 Resident #58 had an intake of 360 milliliters (ml) on first shift, 120 mls on second shift and 360 mls on third shift. An additional 360 mls was indicated on the form. The form also indicated the total consumed was 1200 mls. The output indicated on the | | nottfficatton witthin tthe electtronic medical record.<br>4. Residentts witth specifffic needs (i.e. tted hose) witth be identtffied tthru ttheir care plans DON/designee will conductt ffiacilitty rounds 5x/wk x 6wk tto ensure all intterventtons are implementted DON/Licensed designee will auditt 3 residentts on inttake and outtputt monittoring weekly x3 tto ensure accuratte daily ttottals This will be tthen be monittored tthru QA. montthly unttl 100% compliance is achieved. Administtratto/designee will monittor census line adjusttmentts tto ensure tthe correctt ffiunctton was used This will be done weekly x4 tthen quartterly tthru QA. unttl 100% compliance has been achieved. DON/Licensed designee will monittor nursing documenttatton tto ensure accuratte documenttatton offi physician nottfficatton. This will occur 3x/wk x 4wk tthen montthly tthru QA. unttl 100% compliance is achieved.<br>5. Septtember 24, 2011. | |

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| | form was 400 mls on first shift, 600 mls on second shift and 100 mls on third shift. The total for the output category was 2000 mls. The over all total (intake minus output) was 3200 mls.<br><br>In an interview on 8/24/2011 at 1:17 P.M., the Corporate Nurse indicated she was unsure why the electronic charting system was incorrect and correct intake and output records were not accessible.<br><br>3. Resident #91's record was reviewed 8/23/2011 at 2:40 P.M. Resident #91's diagnoses included but were not limited to, stroke, high blood pressure, and heart failure.<br><br>Resident #91 had a feeding tube placed 7/3/2011 related to decline in ability to swallow.<br><br>A request was made to review intake and output records on 8/23/2011.<br><br>On 8/24/2011 at 1:17 P.M., the Corporate Nurse indicated the intake and output records were not correct, the electronic charting system had a flaw and the resident's intake and output records were not able to be viewed in the system. She further indicated she was not able to hand correct the document. | | | |

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| | 4. Resident #100's record was reviewed 8/25/2011 at 1:05 P.M. Resident #100's diagnoses included but were not limited to chronic kidney disease, diabetes, and dementia.<br><br>A physician's order, dated 5/14/2011, indicated to obtain daily weights and call the physician should Resident #100's weight increase by 1 pound or more in a 24 hour period.<br><br>A review of Resident #100's daily weight documentation revealed Resident #100's weight increased from 208.6 to 210 on May 25, 2011; from 209.5 to 213 on May 30, 2011; from 211 to 213 on June 1, 2011; and from 207.4 to 210.2 on June 6, 2011.<br><br>A review of Resident #100's treatment records for May and June 2011 indicated the weights had been obtained, and nurse initials and checkmarks accompanied the weights under the row headed day.<br><br>In an interview on 8/25/2011 at 2:15 P.M., the Director of Nursing indicated the record did not indicate the physician had been notified because of the electronic record system issues.<br><br>On 8/25/2011 at 3:15 P.M., the 300/400 Team Coordinator provided | | | |

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| | documentation via the 24 hour report. The report indicated the physician had been notified of the weight gains on May 25 and 30, and June 1 and 6.<br><br>3.1-50(a)(2)<br>3.1-50 (a)(3) | | | |